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PHYSICIAN-ASSISTED SUICIDE: WHOSE LIFE IS IT ANYWAY?

Catherine L. Bjorck

I. INTRODUCTION

THE cultural taboos over persons committing suicide due to ill health have been broken,¹ and "Americans are taking death into their own hands."² Many people today believe not only that suicide should be accepted for those who are physically suffering and who wish to end their lives, but also that physicians should be permitted to assist in the suicide process.³ In a recent *New York Times*-CBS poll, fifty-three percent of respondents agreed that "doctors should be allowed to assist a severely ill person to commit suicide."⁴ The growing attraction to the assisted suicide movement reflects the idea that "doctors and hospitals have gone too far in their care of the terminally ill."⁵ Over the past fifty years, society has watched the medical community prolong the dying process, a process that is frequently marked by intolerable pain and indignity.⁶ Many individuals no longer consider life at any cost desirable, and are increasingly unwilling to prolong the dying process.⁷ While concentrating on lengthening life at any cost, the medical community has created a backlash of suffering individuals who want to end their lives.⁸ One public opinion poll found that sixty-eight percent of respondents believed that "people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course."⁹ This poll reflects the desire of Americans for the establishment of physician-assisted suicide as an acceptable alternative to suffering so that each individual is able to maintain control over his or her own life and death.

Physician-assisted suicide involves difficult questions of ethics and law.¹⁰

1. Norman K. Denzin, *The Suicide Machine*, SOCIETY, July/Aug. 1992, at 7, 8.

2. *Id.* (quoting C. Wright Mills). "A self-managed death is the only real symbolic violence [that Americans] can wage against the impersonal, structural violence of the postmodern movement." *Id.* Mills correctly predicted that this postmodern movement would be characterized by "the irrational rationalization and bureaucratization of everyday life." *Id.*

3. *Id.* at 9.

4. Elizabeth W. Markson, *Moral Dilemmas*, SOCIETY, July/Aug. 1992, at 4.

5. Denzin, *supra* note 1, at 9.

6. Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229, 2229 (1992).

7. *Id.*

8. *Prosecutor Suspends Effort to Try Suicide Doctor*, AGENCE FRANCE PRESSE, Nov. 24, 1992 (quoting Dr. Kevorkian).

9. Council on Ethical and Judicial Affairs, *supra* note 6, at 2229.

10. William J. Winslade & Kyriakos S. Markides, *Assisted Suicide and Professional Responsibilities*, SOCIETY, July/Aug. 1992, at 16.

Despite this unresolved legal and moral controversy, some physicians openly engage in assisting their patients to die.¹¹ For example, Dr. Timothy E. Quill, a physician from New York, admitted that he had assisted a terminally ill patient in taking her life.¹² Dr. Quill wrote a prescription for barbiturates for one of his patients, knowing that she intended to use the drugs to commit suicide. He confessed that he also told her the dosage necessary to commit suicide. Referring to the aid he provided his patient, Dr. Quill stated: "I wrote the prescription with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free . . . to maintain dignity and control on her own terms."¹³ Dr. Quill's statement reflects the conflict in our society between the desire to grant people full autonomy and dignity, and the desire to comply with current legal and moral standards.

Despite Dr. Quill's confession and New York law — under which individuals convicted of assisted suicide can be sent to prison for five to ten years—a grand jury decided not to indict Dr. Quill.¹⁴ This grand jury decision, in conjunction with the public opinion surveys, seems to point toward ultimate legalization of the practice.¹⁵ Acceptable legal boundaries in physician-assisted suicide must be clarified in light of the increasing number of elderly and terminally ill people in the United States.¹⁶ By the year 2000, persons over the age of sixty-five will comprise the largest age group in the United States.¹⁷ Suicide is one of the projected leading causes of death for this group.¹⁸ Suicide is also projected to be a leading cause of death for the chronically ill, including those dying from AIDS.¹⁹ These statistics, along with growing public concern, demand that new laws be formulated allowing physicians to assist patients in committing suicide without fearing the legal and professional consequences.

Physicians play an important role in assisted suicide because many individuals do not have the medical knowledge and skills to successfully end their own lives. Marjorie Wantz, a woman suffering from a painful pelvic disease, tried to kill herself three different times.²⁰ She said that she "tried everything, short of a gun."²¹ Finally, she convinced Dr. Jack Kevorkian to use his knowledge and resources to help her end her life peacefully.²² When

11. *Id.* at 17.

12. Timothy E. Quill, M.D., *Death and Dignity: A Case of Individualized Decision Making*, 324 *NEW ENG. J. MED.* 691, 693 (1991).

13. *Id.*

14. Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying?: The Public Perspective*, 267 *JAMA* 2658, 2658 (1992).

15. *Id.*

16. Denzin, *supra* note 1, at 8.

17. *Id.*

18. *Id.*

19. *Id.*

20. Pamela Warrick, *Suicides's Partner: Is Jack Kevorkian an Angel of Mercy, or is He a Killer, as Some Critics Charge?: "Society is making Me Dr. Death," He says. "Why Can't They See? I'm Dr. Life?"*, *L.A. TIMES*, Dec. 6, 1992, at E1.

21. *Id.*

22. *Id.* Dr. Jack Kevorkian grew up in Pontiac, Michigan as a first-generation Armenian

medical professionals are prohibited from aiding suffering individuals, it is inevitable that many will attempt to end their lives on their own. The lack of medical knowledge on the part of these individuals could result in botched attempts, and the suffering person may actually worsen his or her condition.

Further, only a handful of people say they would feel comfortable asking relatives or friends to assist them in committing suicide, and most people say that even if they were asked to provide such assistance, they would not personally assist a relative or friend in ending his or her life.²³ When Sherry Miller, a woman suffering from multiple sclerosis, decided to end her life, her brother respected her judgment but "could not put the needle in her arm."²⁴ Suffering patients, such as Sherry Miller, will turn to their doctors for help and "the burden to act . . . will ultimately rest with the attending physician."²⁵ Legalizing physician-assisted suicide will allow terminally ill and suffering patients to end their lives somewhat autonomously, with the dignity each human being deserves.

II. DISTINCTION BETWEEN ASSISTED SUICIDE AND EUTHANASIA

In proceeding with this analysis, the distinction between euthanasia and physician-assisted suicide must be made. The two forms of death differ primarily in the degree of the physician's participation.²⁶ Euthanasia occurs when a physician performs the action which ends the patient's life, such as giving a lethal injection.²⁷ Assisted suicide occurs when a physician provides the means and information necessary for the patient to perform the life-ending action, such as giving a prescription for sleeping pills and information about the lethal dose.²⁸

Doctors and patients, alike, prefer physician-assisted suicide over euthanasia for both ethical and legal reasons.²⁹ Physician-assisted suicide is "an ethically more attractive option" because it affords the patient a more autonomous way of ending his or her life than does euthanasia.³⁰ The one who actually performs the life-ending act is the patient.³¹ Thus patients have "the added protection of being able to change their minds" and abort the suicide at the last minute.³² Physician-assisted suicide is legally preferable to euthanasia because it destroys the causation factor necessary for the physi-

in a highly traditional and conservative family. He is devoted to helping suffering patients end their lives, but never charges his patients for his assistance. *Id.*

23. Blendon, *supra* note 14, at 2662.

24. Warrick, *supra* note 20, at E1.

25. Blendon, *supra* note 14, at 2662.

26. Council on Ethical and Judicial Affairs, *supra* note 6, at 2229.

27. *Id.* This comment uses the word "euthanasia" in the same way that some scholars use the phrase "active euthanasia" (as opposed to "passive euthanasia").

28. *Id.*

29. *See id.* at 2232.

30. *Id.*

31. John J. Conley, *Masks of Autonomy*, SOCIETY, July/Aug. 1992, at 11.

32. Council on Ethical and Judicial Affairs, *supra* note 6, at 2232.

cian to be held criminally liable for homicide.³³ Since the patient actually causes the death, the physician is absolved from criminal liability in those states that do not have specific statutes prohibiting assisted suicide.³⁴

III. THE REASON FOR PHYSICIAN-ASSISTED SUICIDE: INDIVIDUAL CASES WHERE SUICIDE WAS THE "RATIONAL" ALTERNATIVE

The most grievous problem with the current illegality of physician-assisted suicide is that some terminally-ill people are forced to suffer horribly. Persons with debilitating and painful diseases are forced to remain living, frequently against their will. The lack of a choice between a painful life or a peaceful death strips them of their personal dignity. The following case studies illustrate four of the many situations in which individuals are in such pain that they view death as the only rational choice.

During the two and a half years before she took her life, Marjorie Wantz was tormented by chronic pelvic pain.³⁵ After ten operations, doctors still could not determine the cause of her pain.³⁶ The pain made it almost impossible for her to walk, and she was unable to sleep for more than a couple of hours at a time.³⁷ The constant suffering drove this mother of two to attempt suicide three times, yet she was unsuccessful in each attempt.³⁸ She needed the aid of a medical professional in order to end her life. She plead with Dr. Kevorkian many times to help her commit suicide through the use of his suicide machine.³⁹ Dr. Kevorkian chose to help her, but not until her doctors said there was no hope of recovery from the disease or relief from

33. See generally William Douglas, *'Dr. Death' to Face Murder Charges*, NEWSDAY (City Ed.), Feb. 29, 1992, at 2.

34. *Id.*

35. D'Arcy Jenish, *Death Defined*, MACLEAN'S, Aug. 26, 1991, at 40.

36. *Id.*

37. *Id.*

38. Warrick, *supra* note 20, at E1. "'I want to die,' says Marjorie Wantz. 'I've tried [to kill] myself three different times . . . tried everything, short of a gun. This time,' she says and looks warmly at Kevorkian, 'it will be done right.'" *Id.* (demonstrating the problems of botched suicide attempts that can occur if aid of physicians in the suicide process is not allowed).

39. Jenish, *supra* note 35, at 41. Dr. Kevorkian wanted to create a suicide machine that would allow a rapid, serene, and sure death. DR. JACK KEVORKIAN, PRESCRIPTION — MEDICINE: THE GOODNESS OF PLANNED DEATH 208 (1991). He also wanted the machine to self-administer an injection in order to avoid then current laws that subjected doctors to voluntary-manslaughter charges for killing patients by injection. *Id.* The self-administering nature of this machine also reduced the "moral vulnerability" of the assisting person. Dr. Kevorkian created a suicide machine with these qualifications, which he called the "Mercitron." The Mercitron has an I.V. drip of normal saline solution with a special mechanism which is activated by the patient when he or she presses a hair-trigger switch. The special mechanism performs several functions. The first three are simultaneous: the saline drip is discontinued, there is a rapid infusion of a large dose of thiopental through tubing connected to the I.V. needle, and a timer is activated. One minute later the timer starts a rapid infusion of concentrated potassium chloride solution to flow concurrently with the thiopental through the I.V. needle. The timer also turns off the device, but the solutions continue to flow. The patient is put into a deep coma within 20 to 30 seconds after the thiopental solution is administered, and the potassium chloride paralyzes the heart muscle within several minutes. *Id.* at 209. The patient will have had a painless heart attack while in deep sleep, and death will probably occur

the pain.⁴⁰ When Marjorie did finally end her life with the help of the suicide machine, she escaped the suffering associated with a slow and painful death.⁴¹

Lois Hawes had severe lung cancer which had spread to her brain.⁴² She had been diagnosed as terminal, and she "feared lapsing into a coma and confronting her family with the decision to withdraw life-support systems."⁴³ Lois was experiencing extreme physical pain, and she turned to Dr. Kevorkian for help in ending her life.⁴⁴ Physicians treating Lois showed their acceptance of her decision by meeting with Dr. Kevorkian and discussing her case.⁴⁵ These physicians cooperated with Dr. Kevorkian by sharing medical records and consulting with him on Lois's physical and mental condition.⁴⁶ In a videotaped statement filmed just before she took her life, Lois tried to maintain a dignified facade, but she groaned involuntarily from pain and moaned as she spoke faltering sentences about her wish to die.⁴⁷ Both her physicians' and Dr. Kevorkian's respect for her decision to end her life allowed Lois to do so in peace and on her own terms.

Marcella Lawrence, a retired nurse, suffered from heart disease, emphysema, osteoporosis, and a failing liver.⁴⁸ Her extreme pain led her to the decision that she was ready to die, and she turned to Dr. Kevorkian for help.⁴⁹ Dr. Kevorkian, however, encouraged her not to give up. Marcella then went from specialist to specialist in an attempt to alleviate some of her torturous pain, but nothing would take it away. She finally felt she had suffered too much and she was ready to end her life. Dr. Kevorkian—recognizing Marcella's excruciating pain, the futility of medicine to alleviate that pain, and her readiness to die—assisted her in ending her life.⁵⁰

Diane (last name unpublished) was a woman with leukemia who suffered all of the traditional symptoms: bone pain, weakness, fatigue, and fevers.⁵¹ Diane was extremely fearful of a lingering death. When the time came, she wanted to take her life in the least painful way possible. She consulted with her physician, Dr. Timothy Quill, about how she could attain this wish. Dr. Quill acknowledged and explored her request, but felt that the request was out of the realm of currently accepted medical practice and more than he

within three to six minutes after the device is activated. Janet Adkins was the first patient who used the Mercitron. *Id.* at 210.

40. Jenish, *supra* note 35, at 41.

41. Douglas, *supra* note 33, at 2.

42. Robert Ourlian & Elizabeth Atkins, *Supporters of 'Dr. Death' See New Era in Assisted Suicides*, Gannett News Service, Sept. 28, 1992.

43. *Id.*

44. U.S. "Suicide Doctor" Assists Fifth Death, REUTERS, Sept. 26, 1992.

45. Ourlian & Atkins, *supra* note 42.

46. U.S. "Suicide Doctor" Assists Fifth Death, *supra* note 44.

47. Ourlian & Atkins, *supra* note 42.

48. Michael Abramowitz, *Kevorkian Aids in 2 More Suicides; Michigan Governor Signs Bill Making Practice a Felony*, WASH. POST, Dec. 16, 1992, at A2; *Suicide Doctor Helps Two More End Lives*, REUTERS, Dec. 15, 1992.

49. Warrick, *supra* note 20, at E1.

50. *Id.*

51. Quill, *supra* note 12, at 693.

could offer or promise. Dr. Quill, however, soon came to realize that Diane's fearful preoccupation with a lingering death would interfere with her ability to get the most out of the time she had left with her family. It was "extraordinarily important" to Diane that she retain control over her life. Diane again met with her doctor and requested a prescription for barbiturates. Dr. Quill believed that the security of having the barbiturates available to commit suicide, if the time came, would leave her secure enough to live fully and concentrate on the present. Diane was not despondent during this time; rather, she was making deep, personal connections with her family and friends. Dr. Quill wrote the prescription and made sure she knew the proper amount for a lethal dose.

When the time came for Diane to choose, she chose to die rather than to continue living in pain. Her family had no doubts about the course she had chosen or about their cooperation. They were content with the knowledge that she had died by her own choice.

Marjorie, Lois, Marcella, and Diane were each fortunate to find a doctor who respected their beliefs enough to give them the autonomy to choose how and when to end their lives. Many physicians would not have been so willing to help a suffering patient because of a fear of the legal and professional consequences. Although it is commendable that Dr. Quill and Dr. Kevorkian wanted to help these women, the doctors' actions need to be accompanied by strict regulation in order to insure that patients are not coerced into committing suicide by doctors, relatives, or friends. Legislation allowing physician-assisted suicide would permit individuals to successfully take their lives with the help of a medical professional but would also provide procedural safeguards to prevent abuse of the practice.

IV. POTENTIAL PROBLEMS AND SOLUTIONS

A. CRITICISMS OF LEGALIZING PHYSICIAN-ASSISTED SUICIDE

Opponents of physician-assisted suicide fear that legalizing the practice would make it a definite option for doctors to kill their patients.⁵² The option, however, is not, and should not be, left to the doctor. Rather, the patient decides to end his or her life and actually performs the life-ending act. The doctor is just a medical professional with the knowledge and resources to aid a patient endeavoring to end his or her life. The physician, after determining that the patient meets a rigid and specific set of criteria, would assist the patient by providing only the means of suicide. The physician, however, would not commit the final act.⁵³ The patient controls the dying process. Furthermore, the legalization of physician-assisted suicide, alone, does not mean that most people would choose that option. Those who are opposed to the practice may of course choose to live out their natural lives, but the right

52. Joyce Price, *Michigan Committee Approves Assisted-Suicide Bill*, WASH. TIMES, Oct. 8, 1992, at A5.

53. Gale Scott, *Suicide: A Kinder, Gentler Way to Die?*, NEWSDAY, Dec. 2, 1992, at 89.

to choose between life and death is important to each individual and should not be limited.

Another argument presented against legalizing physician-assisted suicide is that individuals do not need to fear excessive pain as they face their final days because "[t]he medical profession is well-equipped to provide proper medications to keep us comfortable, and allow us to complete our earthly journey in grace-filled peace."⁵⁴ While modern medicine is well-equipped to slow the dying process, modern medicine is not always equally able to stop unbearable pain.⁵⁵ Dr. Timothy Quill stated that even "[i]n the face of excellent palliative care, hospice care, severe suffering still occurs."⁵⁶ The stories of Marjorie Wantz, Lois Hawes, Marcella Lawrence, and others mentioned throughout this comment, all attest to the fact that medical technology cannot always alleviate physical pain.⁵⁷ Although these persons suffered from different diseases, they all shared one thing in common: severe pain and a fierce desire to end their lives with dignity.

Another criticism of legalizing physician-assisted suicide is that it will create a slippery slope which will disrupt the doctor-patient relationship.⁵⁸ Critics fear that physician-assisted suicide would bring into question motivations of the physician.⁵⁹ The patient, however, is the one who has control over his own death. No additional power is put in the hands of the physician.⁶⁰ The physician serves merely as an advisor and a provider of the means by which the patient can end his or her life.

Another danger which critics fear is that such a change in policy will lead to a societal view that some lives are dispensable.⁶¹ Critics contend that "the day may come when ill patients . . . will be dosed with poison without their consent, to speed the inevitable death and save money."⁶² Strict safeguards on the system, however, would prevent such a possibility. The voluntary nature of assisted suicide and the professionalism of physicians would also help prevent this slippery slope.⁶³ The very basis of physician-assisted suicide is that individuals make the decision to either continue to live or to die. The choice is not in the hands of the doctor, family members, or the government; rather, it belongs to each individual. Since the decision to end one's

54. *Cardinal Mahony Urges Defeat of Euthanasia Proposition*, UPI, Oct. 30, 1992. Cardinal Roger Mahony urged his 3.4 million member flock to pray for the defeat of an initiative in California that would legalize physician-assisted suicide, calling the initiative unnecessary and dangerous. *Id.*

55. See Paul Jacobs, *Quietly, Doctors Already Help Terminal Patients Die; Ethics: A West-side Physician Tells of Two "Caring Acts." Prop. 161, to Legalize Such Aid, Divides the Medical Field*, L.A. TIMES, Sept. 29, 1992, at A1.

56. *California: Health Propositions — Do They Have a Future?*, HEALTH LINE, Nov. 5, 1992.

57. *Another Suicide Aided by Controversial Doctor*, CHI. TRIB., Sept. 27, 1992, at C4; see also Abramowitz, *supra* note 48, at A2; B.D. Colen, *Gender Question in Assisted Suicide*, NEWSDAY, Nov. 25, 1992, at 17; Ourlian & Atkins, *supra* note 42.

58. *California: Health Propositions*, *supra* note 56.

59. *Id.*

60. *Id.*

61. *What Role for Doctors in Dying?*, CHI. TRIB., Nov. 2, 1992, at C12.

62. *Id.*

63. *What is the "Good Death"?*, ECONOMIST, July 20, 1991, at 24.

life with assistance belongs solely to the suffering individual, the patient's life would not become dispensable at the request of anyone else.

B. SAFEGUARDS AGAINST ABUSE

As noted above, critics of assisted suicide fear that its legalization will lead to rampant abuses.⁶⁴ When considering assisted suicide as a public policy, society must insure that proper safeguards are in place to prevent potential abuse.⁶⁵ Three considerations should dominate the analysis of safeguarding policy: "1) Does the action enhance the dignity of the person? 2) Is it the result of the person's self-determination? 3) Does it reflect compassion for the person and others?"⁶⁶

Public policy should insure that only mature, mentally competent adults with acceptable reasons are allowed to make the decision to commit assisted suicide.⁶⁷ Statutes should be formulated which would specify rigid guidelines for the allowance of physician-assisted suicide. The decision to terminate life should be made by the patient and should be accepted only after the patient has undergone mandatory psychiatric examinations, has been counseled on alternatives, and has explored all options.⁶⁸ If the patient still maintains his or her desire to commit suicide with assistance, a suitable waiting period should be required in order to avoid hasty decisions.⁶⁹ At that point, a court hearing should be held so that a judge can assure that the decision to die is a result of the patient's wish and not the result of pressure from others. Such requirements would prevent the mentally unstable, the temporarily depressed, or the immature, from ending their lives.⁷⁰ A system with these types of safeguards would prevent abuse while allowing individuals who anticipate a life of misery to choose death with dignity.⁷¹

V. JUDICIAL AND LEGISLATIVE TREATMENT OF PHYSICIAN-ASSISTED SUICIDE

A. SURVEY OF THE LAWS REGARDING PHYSICIAN-ASSISTED SUICIDE

Current American law provides little guidance as to who has the right to decide whether a life should be ended and what the safeguards surrounding this decision should be.⁷² Some states carry laws on their books which posit that a person who assists a suicide is guilty of manslaughter,⁷³ another state calls assisted suicide "murder,"⁷⁴ and others are completely silent on the

64. See William McCord, *Dignity, Choice, and Care*, SOCIETY, July/Aug. 1992, at 20-23.

65. *Id.* at 23.

66. *Id.*

67. *Id.* at 24.

68. *What Role for Doctors in Dying?*, *supra* note 61, at C12.

69. McCord, *supra* note 64, at 24.

70. *Id.*

71. *Id.*

72. *Id.* at 20.

73. *Id.* (The states are Alaska, Arizona, Arkansas, Colorado, Connecticut, and Oregon).

74. *Suicide Doctor Helps Two More End Lives*, *supra* note 48. (Michigan Governor John

issue.⁷⁵ The laws of many states allow one to commit suicide legally, yet prohibit aid by another in completing the act.⁷⁶ This divergence of American laws regarding assisted suicide has led to confusion and disorder.

At this time, twenty-five states in America have statutes expressly prohibiting one person from assisting in another's suicide.⁷⁷ The statutes of the remaining states do not legislatively provide for the act of assisted suicide.⁷⁸ This omission has led to confusion over how to deal with the situation when it occurs.

For example, in Michigan, suicide machine inventor Dr. Jack Kevorkian has to date assisted seventeen ill persons in committing suicide.⁷⁹ Although

Engler has said that physician-assisted suicide is "murder" and vows to prosecute those who give such assistance. *Id.*

75. McCord, *supra* note 64, at 20 (The states are Alabama, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Missouri, Nevada, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.).

76. George P. Smith II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275, 307 (1989) (citing GLANVILLE WILLIAMS, TEXTBOOK OF CRIMINAL LAW 530, 531 (1978)) (The states are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, and Wisconsin.).

77. ALASKA STAT. § 11.41.120(a)(2) (1992); ARIZ. REV. STAT. ANN. § 13-1103A.3 (1991); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1992); CAL. PENAL CODE § 401 (Deering 1993); COLO. REV. STAT. § 18-3-104(1)(b) (1993); CONN. GEN. STAT. § 53a-56(a)(2) (1993); DEL. CODE ANN. tit. 11, § 645 (1987 & Supp. 1992); FLA. STAT. ANN. § 782.08 (West 1992); KAN. STAT. ANN. § 21-3406 (1988); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1992); MINN. STAT. § 609.215 (1987 & Supp. 1992); MISS. CODE ANN. § 97-3-49 (1991); MONT. CODE ANN. § 45-5-105 (1991); NEB. REV. STAT. § 28-307 (1989); N.H. REV. STAT. ANN. § 630:4 (1991); N.J. REV. STAT. § 2C:11-6 (1991); N.M. STAT. ANN. § 30-2-4 (Michie 1992); N.Y. PENAL LAW § 120.30 (Consol. 1992); N.D. CENT. CODE § 12.1-16-04 (1991); OKLA. STAT. tit. 21, § 813 (1991); OR. REV. STAT. § 163.125(1)(b) (1991); 18 PA. CONS. STAT. § 2505(B) (1990); S.D. CODIFIED LAWS ANN. § 22-16-37 (1992); TEX. PENAL CODE ANN. § 22.08 (West 1989); WIS. STAT. § 940.12 (1989-1990).

78. These states include Alabama, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

79. *Another Suicide Aided by Controversial Doctor*, *supra* note 57, at C4; Abramowitz, *supra* note 48, at A2; Ourlian & Atkins, *supra* note 42; Colen, *supra* note 57, at 17; *Why Dr. Kevorkian Was Called In*, N.Y. TIMES, Jan. 25, 1993, at A16; *Kevorkian Assists in Suicides of Two Elderly Cancer Victims*, L.A. TIMES, Feb. 5, 1993, at A14; *Kevorkian Helps Woman in "Medicide"*, *His Twelfth*, L.A. TIMES, Feb. 9, 1993, at A19; *Kevorkian Assists in Thirteenth Suicide Case*, L.A. TIMES, Feb. 16, 1993, at A16; *Kevorkian Aids in Two More Suicides; Total is at Fifteen*, N.Y. TIMES, Feb. 19, 1993, at A10; *Kevorkian Faces Charge That Will Test Suicide Law*, DALLAS MORNING NEWS, Aug. 18, 1993 at A1. The seventeen individuals whom Kevorkian assisted in ending their lives are Janet Adkins, 54, of Portland, Oregon, who suffered from Alzheimers; Marjorie Wantz, 58, of Sodus, Michigan, who suffered from a pelvic disease; Sherry Miller, 43, of Roseville, Michigan, who suffered from multiple sclerosis; Susan Williams, 52, of Clawson, Michigan, who suffered from multiple sclerosis; Lois Hawes, 52, of Warren, Michigan, who suffered from terminal lung cancer; Catherine A. Andreyev, 45, of Moon Township, Pennsylvania, who suffered from cancer; Marguerite Tate, 70, of Auburn Hills, Michigan, who suffered from Lou Gehrig's disease; Marcella Lawrence, 67, of Mt. Clemens, Michigan, who suffered from heart disease, emphysema, and a failing liver; Jack Miller, 53, of Detroit, Michigan, who suffered from bone cancer and emphysema; Stanley Ball, 82, of Leland, Michigan, who suffered from pancreatic cancer; Mary Biernat, 73, of Crown

Michigan law did not expressly prohibit such actions, the state charged Dr. Kevorkian with murder.⁸⁰ An examination of the way in which Michigan handled Dr. Kevorkian's actions shows that states need to expressly address physician-assisted suicide.

In 1990, Dr. Kevorkian helped Janet Adkins, an Alzheimer's patient, kill herself.⁸¹ Dr. Kevorkian provided Janet with a suicide machine and explained to her how to use it.⁸² The essence of this suicide machine "is its ability to permit an individual to intentionally self-administer a lethal dose of drugs."⁸³ Dr. Kevorkian was charged with first-degree murder for his role in assisting Janet in ending her life.⁸⁴ In regard to such charges, Dr. Kevorkian has said that he is a "physician, unconditionally dedicated to the honorable and ethical practice of alleviating hopelessly irremediable physical suffering."⁸⁵ A Michigan judge subsequently dismissed the charges because there was no law prohibiting the action.⁸⁶ The judge, however, did order Dr. Kevorkian not to assist any more suicides.⁸⁷

Then in October 1991, Dr. Kevorkian helped Marjorie Wantz and Sherry Miller, two women who suffered from painful and debilitating diseases, end their lives.⁸⁸ In these cases, Dr. Kevorkian also provided each woman with a mechanical suicide device he had invented but which the patients activated themselves.⁸⁹ In spite of the prior dismissal of charges against Dr. Kevorkian in the Janet Adkins case, another Michigan judge ruled that Dr. Kevorkian must again stand trial on murder charges.⁹⁰ The judge said that it was unclear who had actually activated the two suicide devices, claiming that the causation factor was a question of fact for the jury to determine at trial.⁹¹ Even the prosecution, however, conceded that the patients themselves had

Point, Indiana, who suffered from breast cancer; Elaine Goldbaum, 47, of Detroit, Michigan, who suffered from multiple sclerosis; Hugh Gale, 70, of Detroit, Michigan, who suffered from emphysema and congestive heart disease; Jonathon Grenz, 44, of Costa Mesa, California, who suffered from throat cancer; Martha Ruwart, 40, of San Diego, California, who suffered from both intestinal and ovarian cancer; Ronald Mansur, 54, of Southfield, Michigan, who suffered from lung and bone cancer; and Thomas Hyde, 30, of Wayne County, Michigan, who suffered from Lou Gehrig's disease. *Id.* at 413.

80. Douglas, *supra* note 33, at 2.

81. *Id.*

82. Jesse C. Vivian, *Drugs, R.P.H.s, Death; Should Pharmacists Dispense Drugs When They Will be Used for Suicide? Includes Case of Jack Kevorkian Legal/Ethical Trends*, 135 *MED. ECON. COMPANY* 55, 55 (1991).

83. *Id.*; see *supra* note 39 for an in-depth discussion of the autonomous nature of the machine's use.

84. *Suicide Machine Inventor to Face Trial*, *L.A. TIMES*, Feb. 29, 1992, at A16.

85. *Id.*

86. *Id.*

87. *Id.*

88. Edward Walsh, *Judge Orders Kevorkian to Trial in Two Deaths; Confrontation Set Up on Right-to-Die Issue*, *WASH. POST*, Feb. 29, 1992, at A3.

89. *Id.* Sherry Miller died by inhaling carbon monoxide through a machine similar in principle to the Mercitron. The patient places a mask over his or her face. The mask is connected by plastic tubing to a canister of carbon monoxide. When the patient pulls the clip off the plastic tubing, the carbon monoxide flows into the mask which leads to sleep and then death. *Why Dr. Kevorkian Was Called In*, *supra* note 79, at A16.

90. Douglas, *supra* note 33, at 2.

91. Walsh, *supra* note 88, at A3.

pressed the button that began the death process.⁹² Thus, the State of Michigan relied on faulty logic in order to hold Kevorkian responsible for first-degree murder.⁹³ Not surprisingly, six months after the murder charges were made, they were dismissed by a judge who noted that the state of Michigan had no law barring physician-assisted suicide.⁹⁴

While the murder charges against Kevorkian for Miller's and Wantz's deaths were pending, Kevorkian helped Susan Williams, a multiple sclerosis patient, kill herself at her home in Michigan.⁹⁵ Within two months of the murder charges for Miller's and Wantz's deaths being dismissed, Dr. Kevorkian helped Lois F. Hawes commit suicide.⁹⁶ As in the previous cases, Dr. Kevorkian provided Lois with a suicide machine which was activated by Lois herself. No charges were filed by Michigan in connection with either of these deaths.⁹⁷ The State of Michigan apparently realized that it could not hold someone criminally responsible for an act not addressed in the state's criminal statutes.

Thus, when Dr. Kevorkian assisted Catherine A. Andreyev, a woman suffering from cancer, in ending her life in November of 1992, the Michigan House responded by voting to make assisted suicide a felony.⁹⁸ Rather than protecting Dr. Kevorkian, Michigan's legislative response to the legal ambiguity over the issue of physician-assisted suicide was to pass a temporary law which the state felt would stop Dr. Kevorkian.⁹⁹ In reaction to passage of the bill, Dr. Kevorkian said that "[i]t's essentially a bill against one person. It's like we're still in the Dark Ages."¹⁰⁰ Some health professionals say that the bill, designed to put Dr. Jack Kevorkian out of the suicide business, will hurt their efforts to relieve the pain of terminally ill patients.¹⁰¹ These health experts contend that doctors will be leery about withholding or withdrawing life-sustaining treatment or giving potentially lethal pain medication in fear of prosecution for assisting a suicide.¹⁰²

Michigan's law is a temporary measure which expires fifteen months after it takes effect.¹⁰³ The law makes assisted suicide a felony punishable by up to four years in prison and a \$2,000 fine.¹⁰⁴ The statute also establishes a commission on death and dying, the charter of which is to study the issue of physician-assisted suicide more thoroughly and make recommendations for

92. McCord, *supra* note 64, at 20.

93. See generally *Victory for Dr. Death*, TIME, Aug. 3, 1992, at 28.

94. *Id.*

95. *Another Suicide Aided by Controversial Doctor*, *supra* note 57, at C4.

96. *Id.*; see *supra* notes 42-47 and accompanying text.

97. *Another Suicide Aided by Controversial Doctor*, *supra* note 57, at C4.

98. Colen, *supra* note 57, at 17.

99. Abramowitz, *supra* note 48, at A2.

100. Isabel Wilkerson, *Sixth Assisted Suicide Forges Michigan Bill*, CHI. TRIB., Nov. 26, 1992, at C6.

101. Michael Betzold, *Michigan's Suicide Bill No Cure-All*, CHI. TRIB., Nov. 27, 1992, at C5.

102. *Id.*

103. *Kevorkian Aids Ninth Suicide*, N.Y. TIMES, Jan. 21, 1993, at A21.

104. *Id.*; Abramowitz, *supra* note 48, at A2.

future legislation.¹⁰⁵

The governor of Michigan signed the bill on December 16, 1992, just hours after Dr. Kevorkian helped two more women end their own lives.¹⁰⁶ Two weeks before the governor signed the bill, the women appeared with Kevorkian at a news conference criticizing the proposed law.¹⁰⁷ "The pain I have, I just wish . . . [the lawmakers] could have for one night. If I was up on the [thirteenth] floor, I think I'd jump," said Marcella Lawrence, who suffered from heart disease, emphysema, and a failing liver.¹⁰⁸ Marguerite Tate, who suffered from Lou Gehrig's disease, said she too was ready to die.¹⁰⁹ Both women complained of torturous pain and said that they simply could no longer go on.¹¹⁰ At the conference, Dr. Kevorkian called the law "immoral" and said he would not obey it.¹¹¹ The governor of Michigan stated that if Dr. Kevorkian "does something after this law takes effect, he'll be promptly prosecuted and I think that may be the only way this man can be stopped."¹¹²

The law went into effect on March 30, 1993, and a flurry of gravely ill people sought Dr. Kevorkian's help in dying before that date.¹¹³ Although he had many more requests for assistance than he could possibly handle, Dr. Kevorkian did assist a number of these individuals. These people were worried that after the law took effect Dr. Kevorkian would be unwilling to assist them, or if held for prosecution, unable to assist them.¹¹⁴ Since the ban took effect, however, Dr. Kevorkian has continued to assist persons in ending their lives.¹¹⁵ Dr. Kevorkian has publicly acknowledged breaking the law and asked prosecutors to charge him in order to set up a court test.¹¹⁶ As of the date of this comment, Dr. Kevorkian has been charged and is awaiting prosecution.¹¹⁷ Meanwhile, the law against physician-assisted suicide is under review by the Michigan Court of Appeals, which is not expected to rule for many months.¹¹⁸

Criticism of the Michigan law has been widespread, coming from both individuals and powerful groups. Elmer Ferguson, a thirty-seven year old father of three, is not dying yet.¹¹⁹ He suffers, however, from melanoma cancer which could someday force him to live in severe agony.¹²⁰ The can-

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Suicide Doctor Helps Two More End Lives*, *supra* note 48.

110. Abramowitz, *supra* note 48, at A2.

111. *Suicide Doctor Helps Two More End Lives*, *supra* note 48.

112. *Id.*

113. *Kevorkian Assists in Suicides of Two Elderly Cancer Victims*, *supra* note 79, at A14.

114. *Kevorkian Aids in Two More Suicides; Total is at Fifteen*, *supra* note 79, at A10.

115. *Kevorkian Faces Charge That Will Test Suicide Law*, DALLAS MORNING NEWS, Aug. 18, 1993, at A1.

116. *Id.*

117. *Id.*

118. *Id.*

119. Greg Borowski, *Assisted Suicide Ban Frightens Man With Cancer*, Gannett News Service, Dec. 2, 1992, available in LEXIS, Nexis Library, GNS File.

120. *Id.*

cer may even force him to choose between "living in pain and dying in peace."¹²¹ Elmer could very well be a candidate for assisted suicide one day, and he wants to keep that option open.¹²² He fears the new law in Michigan will take away his freedom of choice.¹²³ "I am not [a] government issue," he said, "I believe all this should be between you and God."¹²⁴ Elmer may get to the point someday where he feels that the pain is too much to handle, and he wants to be able to make his own choices at that time.¹²⁵ "It scares me; we don't have freedom of choice any more," he says.¹²⁶

Other critics of the law have said that it is too vague to withstand a judicial challenge and may be inconsistent with the Supreme Court ruling regarding the right to die.¹²⁷ The American Civil Liberties Union plans to challenge the constitutionality of the law on the ground that it invades personal privacy.¹²⁸ Critics further allege that the law was pushed through the legislature to halt Kevorkian, who advocates public acceptance of physician-assisted suicide.¹²⁹ The Hemlock Society, an organization which supports aid in dying for the terminally ill, issued a statement regarding its feelings toward the law:

The recent bill provides only a Band-Aid solution to a problem pervasive in the medical community. Modern medicine, while able to extend life, has so far been unable to deal with the ethical issues arising from that extension of life. Rather than passing laws prohibiting one physician from acting according to his conscience, the legislatures of all states should expedite the passage of laws legalizing physician-assisted suicide for the terminally ill, while assuring that health care and symptom control are available to all.¹³⁰

The judicial treatment of this issue in Michigan makes it clear that laws need to be formulated that will both protect physicians from threatened prosecutions that are unfounded in current state law and allow them to aid suffering patients in ending their own lives. The laws must also include rigid guidelines to protect the patient from possible abuses of the practice.¹³¹

VI. SUPPORT FOR PHYSICIAN-ASSISTED SUICIDE

A. PUBLIC SUPPORT FOR INITIATIVES WHICH PUSH FOR ACCEPTANCE OF PHYSICIAN-ASSISTED SUICIDE

Citizens of Washington State voted on an initiative to legalize physician

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. Linda Wertheimer & Robert Siegel, hosts, National Public Radio, Dec. 16, 1992, available in LEXIS, Nexis Library, NPR File; see *supra* part IV.B.

128. Betzold, *supra* note 101, at C29.

129. Wertheimer & Siegel, *supra* note 127.

130. *Hemlock Society Comments on Michigan Deaths*, PR Newswire, Dec. 15, 1992, available in LEXIS, Nexis Library, PRNews File.

131. See *supra* notes 67-71 and accompanying text.

aid-in-dying in November of 1991.¹³² The initiative asked the question: "Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?"¹³³ The voters answered no, but by a very narrow margin.¹³⁴ The initiative failed by fewer than 100,000 of 1.3 million votes cast.¹³⁵ Support for the initiative was widely interpreted as "a criticism of both existing law and the inability of many physicians to properly manage the chronic pain of terminally ill patients."¹³⁶ Further, many physicians that voted no said that they did so because the current proposal to provide physician aid-in-dying lacked safeguards for "the poor, for the depressed, for families, for people in pain, for the mentally incompetent, for seniors, and for society."¹³⁷ A bill with proper safeguards is necessary to protect those patients who could be made vulnerable by the law. The narrow margin by which the initiative was defeated reflects the growing attitude that physician-assisted suicide should be legalized with proper protections.

In California, where assisted suicide is presently a felony,¹³⁸ Proposition 161, a measure legalizing physician-assisted suicide, was on the November, 1992 ballot.¹³⁹ Forty-six percent of California voters voted for the measure, which lost by a margin of only eight percent.¹⁴⁰ Although the measure was defeated, 4,557,037 Californians voted to give physicians the right to assist suicides.¹⁴¹ Of the Californians that voted against Proposition 161, some voted "no" because of religious reasons, while others voted "no" because they believed the proposed law was flawed.¹⁴² Many doctors were concerned over the wording of the measure, which said the patient's request for death need not be witnessed.¹⁴³ The doctors feared that this wording opened up the possibility of lawsuits against physicians in a state which already has more litigation than any other state in America.¹⁴⁴

Many opponents to Proposition 161 did not feel that physician-assisted suicide is wrong; rather, the "No on 161" supporters believed the initiative was poorly written and invited abuse.¹⁴⁵ The measure did not require a psy-

132. Blendon, *supra* note 14, at 2658.

133. McCord, *supra* note 64, at 20.

134. Blendon, *supra* note 14, at 2658.

135. *Id.*

136. Dennis L. Breo, *MD-Aided Suicide Voted Down; Both Sides Say Debate to Continue*, 266 JAMA 2895, 2895 (1991).

137. *Id.*

138. CAL. PENAL CODE § 401 (Deering 1992).

139. Bruce Hilton, *Nothing But Numbers*, CHI. TRIB., June 10, 1992, at C7.

140. *Where Now With the Euthanasia Debate?*, PR NEWSWIRE, Nov. 17, 1992, available in LEXIS, Nexis Library, PRNews File.

141. B.D. Colen, *Euthanasia Issue Lives On*, NEWSDAY, Nov. 10, 1992, at 71.

142. Derek Humphry, *Death With Dignity Effort May be Tried Here Again*, S.F. CHRON., Nov. 13, 1992, at A25; *Where Now With the Euthanasia Debate?*, *supra* note 140.

143. Michael Miller, *Doctor-Assisted Suicide Measure Loses in California*, REUTERS, Nov. 4, 1992, available in LEXIS, Nexis Library, Reuter File.

144. *Id.*

145. James W. Walters, *Perspective on Prop. 161: Aid in Dying is Human, Humane; Assisted Suicide for the Terminally Ill Doesn't Conflict with Medical or Religious Interests; It Does Respect Individual Rights*, L.A. TIMES, Oct. 18, 1992, at M5.

chological exam or a waiting period.¹⁴⁶ These provisions are necessary safeguards in a bill which allows physician-assisted suicide in order to prevent abuse of the practice.¹⁴⁷ The California initiative would have been strengthened by the addition of such restrictions as mental competency exams to evaluate the decision-making abilities of the patient and a “cooling-off” period of several days to prevent any rash decisions by patients considering ending their lives.¹⁴⁸ The absence of such restrictions was a flaw which promoted the measure’s defeat. California doctor Ronald Koons said that even though Proposition 161 was defeated, the issue of physician-assisted suicide is not dead: “We need to set up guidelines. It is only a question of time before some form of doctor-assisted suicide is law.”¹⁴⁹

In both Washington and California, the opponents of the physician-assisted suicide proposals, led by the medical establishment and the Catholic church, “greatly outspent” the physician-assisted suicide supporters in last-minute media blitzes.¹⁵⁰ California Proposition 161 campaign manager Jack Nicholl said, “We simply could not match their [the opponents’] media campaign.”¹⁵¹ Opponents of Proposition 161 raised \$2.8 million between June and November—the largest amounts coming from Roman Catholic diocese, Catholic hospitals, and church-related groups—while the proponents of the proposition raised only \$215,000.¹⁵²

The disproportionate campaign funding has been cited as the reason for the defeat of the proposals.¹⁵³ Opponents of Proposition 161 ran chilling television ads designed to scare off Californians, including those who had generally favored the idea of physician-assisted suicide before they were bombarded with the media blitz.¹⁵⁴ The ads used phrases like “death by mistake” and “no witnesses, no one will know” to sway Californians.¹⁵⁵ The proponents, with far less money to spend, were only able to air thirty-second radio advertisements a few times per day.¹⁵⁶ Voters were far more likely to see and hear from Proposition 161’s opponents than from its proponents.¹⁵⁷

146. Paul Jacobs & Virginia Ellis, *Prop. 165 and Right-to-Die Measure Trail*, L.A. TIMES, Nov. 4, 1992, at A1.

147. *What Role for Doctors in Dying?*, *supra* note 61, at C12.

In principle, the idea of physician-assisted suicide has appeal. But in practice, it is highly vulnerable to misuse and abuse, which the California measure does little to combat. A prudent approach would include mandatory psychiatric examinations, a specified waiting period to avoid hasty and ill-considered decisions, and a requirement that doctors counsel patients on alternatives, such as methods of relieving severe pain.

Id.

148. Walters, *supra* note 145, at M5.

149. *California: Health Propositions—Do They have a Future?*, *supra* note 56.

150. Colen, *supra* note 57, at 17.

151. *California: Health Propositions*, *supra* note 56.

152. Paul Jacobs, *Proposition 161; Outcome of Death Measure may Rest on 11th-hour Ads*, L.A. TIMES, Oct. 28, 1992, at A3.

153. *See California: Health Propositions*, *supra* note 56.

154. Jacobs, *supra* note 152, at A3.

155. *Id.*

156. *Id.*

157. *See Colen*, *supra* note 141, at 71.

Despite the strong opposition from certain medical societies and a well-funded campaign by the Roman Catholic Church, more than five million people in Washington and California voted for reform.¹⁵⁸ This growing societal restlessness regarding the current state of physician-assisted suicide laws is reflected across the country. Similar initiatives to those in Washington and California can already be found in at least twenty states.¹⁵⁹ New Hampshire legislators are currently debating a bill which would specifically legalize assisted suicide for terminally ill patients after counseling and consultation.¹⁶⁰ This year Connecticut and Virginia will also consider physician-assisted suicide bills.¹⁶¹ Washington is planning to reintroduce an initiative legalizing physician-assisted suicide in 1994, and Oregon is planning to introduce a similar initiative that same year.¹⁶² Iowa and Maine are also considering introducing referenda in the near future regarding the legalization of physician-assisted suicide for dying patients.¹⁶³

The legalization efforts previously discussed indicate that the country seems to be moving towards the formulation of laws allowing physician-assisted suicide and protecting physicians from adverse legal and professional consequences. Society's feelings on this issue are further reflected by a New York grand jury's decision in the Dr. Timothy Quill case.¹⁶⁴ Although New York law makes assisted suicide a felony,¹⁶⁵ when a New York prosecutor sought an indictment against the doctor, criticism of the prosecution was widespread.¹⁶⁶ Significantly, the grand jury refused to indict Dr. Quill in spite of his confession that he intentionally aided one of his patients in ending her life.¹⁶⁷ The grand jury's blatant disregard for the present law is an indicator that society is calling for a change in the laws and is willing to accept the right of suffering patients to end their lives with the aid of a professional. A majority of Americans believe that when a terminally ill patient is conscious and in pain, physicians should be allowed by law to respond to that patient's request for aid in ending his or her life.¹⁶⁸

B. OPEN SUPPORT FROM THE MEDICAL COMMUNITY

Members of the medical community have mixed views on physician-assisted suicide, but it is clear that physicians want specific formulation of policies regarding physician-assisted suicide. When Dr. Timothy Quill was brought before a panel of his peers on an ethics charge for intentionally help-

158. Humphry, *supra* note 142, at A25.

159. Blendon, *supra* note 14, at 2658.

160. Ralph Jimenez, *Legislators Debate Assisted-Suicide Bill*, BOSTON GLOBE, Feb. 7, 1993, at 37.

161. *Id.*

162. *Id.*

163. Hilton, *supra* note 139, at C7.

164. Blendon, *supra* note 14, at 2658; *see supra* notes 12-15 and accompanying text.

165. N.Y. PENAL LAW § 120.30 (Consol. 1992).

166. Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 859 n.11 (1992).

167. Blendon, *supra* note 14, at 2658; Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1.

168. Blendon, *supra* note 14, at 2660.

ing a patient to end her life, the panel found that Dr. Quill had acted appropriately.¹⁶⁹ Dr. Quill openly confessed to the entire medical community his role in the physician-assisted suicide, yet the panel determined that he acted properly and should be allowed to retain his medical license.¹⁷⁰ The peer review board was clearly sending a message to the medical community and the public that the act of physician-assisted suicide should be allowed and is appropriate under certain circumstances. Further, when Dr. Quill was facing criminal indictment for this act, the officers and members of the Council of the Society of General Internal Medicine wrote the District Attorney that Dr. Quill's actions "were consistent with the range of acceptable practice of compassionate physicians . . ." ¹⁷¹

The support for physician-assisted suicide was furthered by an article published by three doctors, including Dr. Quill, in a November, 1992 issue of the *New England Journal of Medicine*.¹⁷² In the article, the doctors urged a new public policy allowing physician-assisted suicides and listed a number of guidelines that they believe their colleagues should follow.¹⁷³ This article is yet another indication from the medical community that at least some of its members are ready to allow physician-assisted suicide based on the premise that the final decision should rest with the dying person and that this right to choose to end one's own life is a basic civil liberty.¹⁷⁴

The article urges physicians and lawyers to "create public policy that fully acknowledges irreversible suffering" for the benefit of "competent patients who [meet] carefully defined criteria."¹⁷⁵ The number of doctors who help their patients commit suicide is estimated to be anywhere from three to thirty-seven percent.¹⁷⁶ The most common method is thought to be prescriptions for drugs which can end life in an easily administered overdose.¹⁷⁷ Dr. Quill and his co-authors say that "such hidden practices" are more risky for patients and damage the reputation of doctors.¹⁷⁸ The authors of the article support the open practice of physician-assisted suicides, as long as clear policies and safeguards are established and followed.¹⁷⁹ Dr. Quill and his colleagues propose several tests that should be met before a doctor participates in a suicide. First, "the patient must have a condition that is incurable and associated with severe, unrelenting suffering . . . and must understand

169. *Doctors Urge Policy on Suicide Help*, CHI. TRIB., Nov. 5, 1992, at C3; *Suicide Assistance Gains New Backing*, N.Y. TIMES, Nov. 5, 1992, at A32.

170. *Doctors Urge Policy on Suicide Help*, *supra* note 169, at C3.

171. Kadish, *supra* note 166, at 859 n.11 (quoting Letter from Robert H. Fletcher, President, Society of General Internal Medicine, to Charles Siragusa, District Attorney, SGIM News (Society of General Internal Medicine) Oct. 1991, at 5).

172. *Suicide Assistance Gains New Backing*, *supra* note 169, at A32; Dr. Timothy Quill et al., *Care of the Hopelessly Ill*, 327 N. ENG. J. MED. 1380 (1992). Dr. Quill's co-authors were Dr. Christine K. Cassel of the University of Chicago and Dr. Diane E. Meir of the Mount Sinai School of Medicine in New York.

173. *Id.* at 1381; *Suicide Assistance*, *supra* note 169, at A32.

174. Humphry, *supra* note 142, at A25.

175. Quill, *supra* note 172, at 1383; *see also Suicide Assistance*, *supra* note 169, at A32.

176. Quill, *supra* note 172, at 1381.

177. *Id.* at 1382.

178. *Id.* at 1383.

179. *Id.* at 1380.

the condition, the prognosis, and the types of comfort care available as alternatives."¹⁸⁰ Second, the doctor must be sure that the "patient's suffering and the request are not the result of inadequate comfort care."¹⁸¹ Third, the patient "must clearly and repeatedly, of his or her own free will and initiative, request to die rather than continue suffering . . . yet it is important not to force the patient to 'beg' for assistance."¹⁸² Fourth, the doctor "must be sure that the patient's judgment is not distorted."¹⁸³ Fifth, the patient and doctor who assists in the suicide should have a "meaningful doctor-patient relationship."¹⁸⁴ Sixth, a "consultation with another experienced physician is required to ensure that the patient's request is voluntary and rational."¹⁸⁵ Clear documentation showing that each condition is met would also be required.¹⁸⁶

The authors say that the family members should be involved in the process, but that "under no circumstances should the family's wishes and requests override those of a competent patient."¹⁸⁷ The authors further stressed that if the doctor provides the medicine, the overdose should be taken in the doctor's presence so that the patient is not abandoned at the critical moment of his or her death.¹⁸⁸ The authors of the article noted that "terminally ill patients who do choose to take their lives often die alone so as not to place their families or care givers in legal jeopardy."¹⁸⁹ Laws allowing physician-assisted suicide must not require the patient to be left alone at the moment of death just to keep those who would agree to assist safe from prosecution.

The fact that the *New England Journal of Medicine* published the article indicates that the editors of one of the nation's premier medical journals not only believe that the subject of physician-assisted suicide is worth exploring, but also believe that it is "safe" to publish articles in support of the practice.¹⁹⁰

Members of the medical community realize that these patients should not have to die alone and without aid, and that physicians should not have to fear repercussions if they answer a suffering patient's plea for help. The doctors who authored the article realize that laws permitting physician-assisted suicide are necessary to protect the rights of both the patient and the doctor.

180. *Id.* at 1381.

181. *Id.* at 1382.

182. *Id.*

183. *Id.*

184. *Id.*; *Suicide Assistance*, *supra* note 169, at A32.

185. Quill, *supra* note 172, at 1382.

186. *Id.*

187. *Id.*

188. *Id.* at 1383.

189. Quill, *supra* note 172, at 1383.

190. *See* Colen, *supra* note 141, at 71.

VII. EXPANSION OF THE CONSTITUTIONAL RIGHT TO DIE TO INCLUDE PHYSICIAN-ASSISTED SUICIDE

A. THE CONSTITUTIONAL RIGHT TO DIE

Any legislation created must be able to pass the hurdle of the Constitution for it to remain good law. The constitutional right to receive assistance in ending one's life should be recognized as an extension of the current constitutional right to die which arises out of both a liberty interest found in the Due Process Clause of the Constitution and a privacy right inherent in the Constitution. Through both the liberty interest of persons and the privacy right, the Supreme Court has developed a jurisprudence of autonomy.¹⁹¹ This autonomy is supported by the Court's finding in the Constitution of a fundamental right of individuals to make choices with regard to their own bodies.¹⁹²

The Supreme Court faced the right to die issue for the first time in *Cruzan v. Director, Missouri Department of Health*.¹⁹³ The Court in *Cruzan* found that a "competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment."¹⁹⁴ The Court inferred this constitutional right from prior Supreme Court decisions.¹⁹⁵ The *Cruzan* Court cited recently decided cases which support the recognition of a general liberty interest in refusing medical treatment.¹⁹⁶ In *Washington v. Harper*¹⁹⁷ which was decided in the same term as *Cruzan*, the court held that "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."¹⁹⁸ The Court has often found that such "state incursions into the body are repugnant to the interests protected by the Due Process Clause."¹⁹⁹ The *Cruzan* Court also cited *Vitek v. Jones*,²⁰⁰ which held that transfer to a mental hospital coupled with mandatory behavior modification treatment implicated liberty interests.²⁰¹ The Court recognized a constitutional right to refuse medical treatment, arising from the general liberty interest which flows from these court decisions involving the state's invasions into an individual's body.²⁰² The *Cruzan* Court assumed that this constitutionally protected right included the right to refuse lifesaving hydration and nutrition.²⁰³ The *Cruzan* Court

191. Kadish, *supra* note 166, at 862.

192. *Id.*

193. 497 U.S. 261 (1990).

194. *Id.* at 278.

195. *Id.*; see, e.g., *Washington v. Harper*, 494 U.S. 210, 221 (1990) (holding that under the Due Process Clause prisoners possess a liberty interest in avoiding the unwanted administration of antipsychotic drugs); *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905) (balancing an individual's liberty interest in declining an unwanted smallpox vaccine against the state's interest in preventing disease).

196. *Cruzan*, 497 U.S. at 278.

197. 494 U.S. 210 (1990).

198. *Id.* at 229.

199. *Cruzan*, 497 U.S. at 283; see, e.g., *Rochin v. California*, 342 U.S. 165, 172 (1952).

200. 445 U.S. 480 (1980).

201. *Id.* at 494.

202. *Cruzan*, 497 U.S. at 278.

203. *Id.* at 279.

noted an individual's privacy right²⁰⁴ but based its finding of a constitutional right to die in the liberty interest found in the Due Process Clause of the Fourteenth Amendment.²⁰⁵

An individual's right to die might also be based on the right to privacy. The Supreme Court first recognized the right to privacy in *Griswold v. Connecticut*.²⁰⁶ In *Griswold* the Court found that "several fundamental constitutional guarantees" created a zone of privacy for individuals.²⁰⁷ Though the "right of privacy" is not explicit in the text of the Constitution, the Court found the right implicit in the First Amendment's doctrine of free thought and association, the Third Amendment's prohibition against the required quartering of soldiers, the Fourth Amendment's freedom from search and seizure, the Fifth Amendment's self-incrimination clause, the Ninth Amendment's grant of unenumerated rights to the people, and the Fourteenth Amendment's idea of personal liberty.²⁰⁸

Although the Supreme Court based its decision in *Cruzan* on the Due Process Clause, lower courts, both before and after the *Cruzan* decision, have protected an individual's right to die based on a privacy right.²⁰⁹ In *In re Quinlan*²¹⁰ the New Jersey Supreme Court expanded the right to privacy to include the right to die.²¹¹ The *Quinlan* court held that a person's constitutionally protected right to privacy presumably includes the right of a patient to refuse life-sustaining treatment in certain circumstances.²¹² Since *Quinlan*, most courts considering the right to die have held that patients have a fundamental constitutional privacy right to withhold or withdraw medical treatment and support that would prolong the dying process.²¹³

B. THE CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE

A constitutional right to die with assistance may be inferred from the Supreme Court's recognition of a constitutional right to refuse medical treatment, just as recognition of that right was inferred from prior Court holdings.²¹⁴ Constitutional protection should extend to the third person whose

204. *Id.* at 271.

205. *Id.* at 278. The Fourteenth Amendment provides that no state shall "deprive any person of life, liberty, or property, without due process of law . . ." U.S. CONST. amend. XIV.

206. 381 U.S. 479 (1965).

207. *Id.* at 485.

208. *Id.* at 484; Irving R. Kaufman, *Perspective on the Constitution; Would Roes's Demise Sink Privacy?: The Modern American Conception of Freedom Includes at Least Some Inviolable Sphere of Private Choice*, L.A. TIMES, Sept. 20, 1991, at B7.

209. Kaufman, *supra* note 208. Laws prohibiting or impeding the choice to use contraceptives, have an abortion, marry one of another race, live with extended family members, and view obscene movies within the home have all been struck down as violations of the right to privacy. *Id.*

210. 355 A.2d 647 (N.J. 1976).

211. *Id.* at 663-64.

212. *Id.*

213. See, e.g., *Rasmussen by Mitchell v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 301 (Cal. Ct. App. 1986) (the right to die is probably the "ultimate" exercise of the right to privacy); *In re Guardianship of Barry*, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984).

214. See *supra* note 195. The idea that legalization of assisted suicide is constitutional has

action is necessary to effectuate the exercise of that right.²¹⁵ Thus, the physicians who assist patients in ending their lives should be constitutionally protected and should not have to fear criminal prosecution.

Judicial acceptance of the constitutionality of assisted suicide may well be the logical development of the combination of judicial authorization for substituted judgment and the withdrawal of life-sustaining food and fluids from patients who are profoundly disabled but neither terminally ill nor imminently dying.²¹⁶ State judicial decisions of the past several years increasingly translate the right to die by refusing medical treatment into the right to die with or without assistance.²¹⁷

In *Bouvia v. Superior Court*²¹⁸ the California Court of Appeals permitted a competent, non-terminally ill patient to end her life through the refusal of food and fluids.²¹⁹ Elizabeth Bouvia was a patient with cerebral palsy and quadriplegia, but she was not terminally ill nor imminently dying. The court in *Bouvia* held that there was no overriding interest requiring the state to preserve the life of a patient in the condition of Elizabeth Bouvia:

We do not believe it is the policy of this state that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure for '15 to 20 years.' We cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone.²²⁰

The concurring opinion of Justice Compton even more explicitly supported a right to assistance in ending one's life:

Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe she has an absolute right to effectuate that decision. This state and the medical profession, instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane. The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.²²¹

Justice Compton's opinion recognizes the importance of allowing a patient

been strongly opposed by some. For a discussion of the unconstitutionality of assisted suicide laws, see Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23 HASTINGS CTR. REP. 32, May-June 1993.

215. *In re Quinlan*, 355 A.2d 647, 670 (N.J. 1976) (citing *Eisenstadt v. Baird*, 405 U.S. 438, 445-46 (1972) and *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965)).

216. Victor G. Rosenblum & Clarke D. Forsythe, *The Right to Assisted Suicide: Protection of Autonomy Or an Open Door to Social Killing?*, 6 ISSUES L. & MED. 3, 13 (1990).

217. *Id.* at 12.

218. 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

219. *Id.* at 298.

220. *Id.* at 305.

221. *Id.* at 307.

to maintain his or her rights to autonomy and self-determination. Further, he stresses that the right to die with assistance protects an individual's interest in self-determination.²²²

The Maine Supreme Court cited the principle of personal autonomy in *In Re Gardner*²²³ when it allowed the withdrawal of food and fluids from a person who was neither terminally ill nor imminently dying. The court allowed the withdrawal based on prior statements made by the patient that he would rather die than be maintained in a persistent vegetative state.²²⁴ The court found "no reason" to disregard the patient's desire and sustain his life when his future was so utterly helpless.²²⁵

The Massachusetts Supreme Court allowed substituted judgment in *Guardianship of Doe* when it made a determination as to whether an incompetent patient in a persistent vegetative state would choose, if the patient were competent, to end life-sustaining treatment.²²⁶ The *Doe* court held that a lack of a previously-expressed intention regarding medical treatment did not bar the use of substituted judgment.²²⁷ The court found that the quality of the patient's life was so poor, that the state's interest in preserving life was not sufficient to override the patient's right to refuse treatment through substituted judgment.²²⁸

In *In re Lawrance*,²²⁹ the Indiana Supreme Court allowed withdrawal of nutrition and hydration from an incompetent patient through substituted judgment. The court held that "respect for patient autonomy does not end when the patient becomes incompetent."²³⁰ The *Lawrance* court recognized the right of the patient to refuse nutrition and hydration and the right of the family of an incompetent patient to refuse it on behalf of the patient.²³¹

These various court decisions have laid the groundwork for the ultimate approval of physician-assisted suicide.²³² The courts have realized that society's interest in the sanctity of human life can depreciate when the actual quality of the life in question is examined. Further, in adopting substituted judgment, courts have allowed incompetent patients to refuse medical treatment regardless of whether they have previously expressed such a desire. This substituted judgment doctrine is based on the reasoning that the patient's right to self-determination may sometimes require the assistance of others.²³³ Substituted judgment allows patients to fulfill their desires to end

222. *Id.*

223. 534 A.2d 947, 951 (Me. 1987).

224. *Id.*

225. *Id.* at 954.

226. *In re Guardianship of Doe*, 583 N.E.2d 1263 (Mass. 1992). "Substituted Judgment" cases are those in which a person now incompetent never exercised a choice when competent. The court seeks to determine what the person's choice would be. Kadish, *supra* note 166, at 878.

227. *Doe*, 583 N.E.2d at 1267.

228. *Id.* at 1269.

229. 579 N.E.2d 32 (Ind. 1991).

230. *Id.* at 39.

231. *Id.* at 41.

232. Rosenblum, *supra* note 216, at 20.

233. *Id.* at 19.

their lives even when they are so ill that they are unable to express these desires themselves.

The constitutional right to refuse medical treatment should be extended to include the right to obtain assistance in committing suicide. Little difference exists between allowing patients to hasten their death by refusing treatment and allowing them to do so by an act of commission with a physician's assistance.²³⁴ In fact, what is the difference between a doctor who starves his patient to death and one who prescribes a dose of medicine and tells the patient what dosage will result in death?²³⁵ Surely a reasonable person would recognize that pulling the plug on a machine and allowing a patient to purchase a lethal dose of morphine for self-administration should both be considered forms of active assistance with the same end result.²³⁶ Because the Constitution protects the withdrawal of life support, constitutional protection should also extend to physician-assisted suicide.

VIII. SELF-DETERMINATION FOR THE INDIVIDUAL WHO CHOOSES TO DIE

Assisted suicide has been proposed as good public policy based on principles of autonomy and self-determination.²³⁷ Patients request assisted suicide because they want control over when they die, where they die, and their physical and mental state at the time of their death.²³⁸ When a suffering patient requested that Dr. Timothy Quill assist her in ending her life, he noted that "it was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her."²³⁹ Supporters of legalizing assisted suicide contend that life itself is only one among a number of goods; other goods include individual autonomy, human dignity, physical fitness, and intellectual capabilities.²⁴⁰ When life as a relative good is compared with the other goods, suicide may become a "rational" choice if life has become "intolerable."²⁴¹ "People ought to be able to be architects of their own death," said University of Utah philosophy professor Margaret P. Battin, who sees the choice of death or life as a "new civil right."²⁴² Patients requesting assisted suicide have argued that their right to privacy and self-determination are "paramount to any state interest in maintaining life" and that there should not be a balancing of interests by the state in determining the existence of such a right.²⁴³ In *Donaldson v. Van De Kamp*²⁴⁴ the

234. *What Role for Doctors in Dying?*, *supra* note 61, at C12.

235. McCord, *supra* note 64, at 20.

236. *Id.*

237. See Rosenblum, *supra* note 216, at 20.

238. Note, *Physician-Assisted Suicide and the Right to Die With Assistance*, 105 HARV. L. REV. 2021, 2025 (1992).

239. Quill, *supra* note 12, at 693.

240. *Id.*

241. *Id.*

242. Paul Jacobs, *California Elections; Proposition 161; Initiative Fuels Debate over Morality of Euthanasia*, L.A. TIMES, Oct. 31, 1992, at A20.

243. *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 61 (Cal. Ct. App. 1992).

244. *Id.*

California Court of Appeals recognized the fundamental right of a patient to take his own life.²⁴⁵ The court realized that the patient's own specific interest in ending his life was more compelling than the state's abstract interest in preserving life in general.²⁴⁶ The court stated that "no state interest is compromised by allowing Donaldson to experience a dignified death rather than an excruciatingly painful life."²⁴⁷ The court in *Donaldson* noted that the time left in a suffering patient's life is critical and that it is a judicial weakness that the court cannot accommodate the special needs of an individual.²⁴⁸

Proponents of assisted suicide believe that the state should not interfere in this final decision.²⁴⁹ They argue that "choices made by rational, consenting people in the pursuit of happiness should be acknowledged as a proper way of asserting their liberty."²⁵⁰ The right to die with assistance protects an individual's interest in self-determination.²⁵¹ Society demonstrates "respect for human dignity when it acknowledges the freedom [of individuals] to make choices in accordance with their own values."²⁵²

IX. ETHICAL PROBLEMS FOR DOCTORS

Critics of assisted suicide also fear that physicians will be corrupted by their assistance in suicide.²⁵³ These critics hold a distinction between assisting a death and allowing a patient to die.²⁵⁴ As previously noted, however, withdrawing medical treatment so that a person will die is an active decision by the physician.²⁵⁵ The physician is actually more involved in the death in such a case than where the doctor writes a prescription for a patient and tells the patient the lethal dosage of the medication, but leaves the ultimate death decision to the patient.²⁵⁶

The point to realize is that in cases of assisted suicide, the patient is the one who makes the final decision.²⁵⁷ The doctor should be a counselor and assistant, but should not control the decision.²⁵⁸ The patient must bear the burden of choice and the exercise of autonomy should be his or her responsibility.²⁵⁹

Critics of legalizing physician-assisted suicide also point to the traditional oath of Hippocrates which requires physicians to promise: "To please no one will I prescribe a deadly drug, nor give advice which may cause

245. *Id.* at 63.

246. *Id.*

247. *Id.*

248. *Id.* at 64.

249. McCord, *supra* note 64, at 23.

250. *Id.* (citation omitted)

251. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986).

252. Council on Ethical and Judicial Affairs, *supra* note 6, at 2229 (citation omitted).

253. McCord, *supra* note 64, at 23.

254. *Id.*

255. *Id.*

256. *Id.*

257. *Id.* at 24.

258. *Id.*

259. *Id.*

death."²⁶⁰ Some members of the medical community, however, have realized that the ability of modern medicine to prolong the dying process sometimes requires physicians to abandon "simple black-and-white rules of conduct."²⁶¹ One California physician who admits helping some of his patients to commit suicide contends that "the Hippocratic Oath is really not the final word any more than the Ten Commandments."²⁶²

X. PHYSICIAN-ASSISTED SUICIDE IN ANOTHER CIVILIZED NATION

Critics of the physician-assisted suicide movement claim that tolerating suicide would do profound harm to society.²⁶³ One way to determine the validity of this prediction is to examine a society that openly practices physician-assisted suicide. In the Netherlands, the practice of assisted suicide is more open and extensive than anywhere else in the modern world.²⁶⁴ Dutch health officials feel that the best control for assisted suicide is "legalization and openness."²⁶⁵

Doctors have assisted suicides for more than two decades even though

260. Jacobs, *supra* note 55, at A1. The medical profession has adopted The Oath of Hippocrates as an ethical code. Hippocrates was a Greek physician of the period of 460 to 349 B.C. The original Oath of Hippocrates follows:

I swear by Apollo Physician, by Asclepius, by Health, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture. To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture.

To impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else.

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly, I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art.

I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein. Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free.

And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now, if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and foreswear myself, may the opposite befall me.

CHARLES J. MCFADDEN, *MEDICAL ETHICS* 396, 461 (1967).

261. Jacobs, *supra* note 55, at A1.

262. *Id.*

263. Robert Barry, *The Paradoxes of "Rational" Death*, *SOCIETY*, July/Aug. 1992, at 25, 27.

264. McCord, *supra* note 64, at 22.

265. *Dutch Parliament OKs Mercy Killing; Strict Guidelines Govern Euthanasia*, *HOUSTON CHRON.*, Feb. 9, 1993, at A1.

Dutch law forbade the practice until 1993.²⁶⁶ In spite of the ban on assisted suicides, however, Dutch courts have condoned physician-assisted suicide for more than a decade and even set forth conditions that excused the doctor from the illegal act.²⁶⁷ The law was seen as more of a restraint than a prohibition.²⁶⁸

In February 1993, Dutch lawmakers passed a law that allows doctors to assist suicides under certain guidelines.²⁶⁹ The measure essentially legalized existing medical guidelines already published and sanctioned by the Royal Dutch Medical Association.²⁷⁰ Although aiding a suicide formally remains illegal, doctors who follow the guidelines in the measure are immune from prosecution.²⁷¹

The guidelines require that the patient, not his or her family, personally request assistance, that the patient suffer from an unbearable and incurable pain, that the patient request death repeatedly, and that the patient be in a clear state of mind.²⁷² The attending physician must maintain specific records of every step in the decision-making process. Furthermore, another physician must be in attendance to provide corroboration that the guidelines were met.²⁷³ Once the patient has died, the doctor must submit a report to the coroner's office.²⁷⁴ As long as the doctor's report shows that the guidelines were followed and that there is no evidence of malpractice, the doctor will remain immune from prosecution.²⁷⁵

A government report showed that 25,300 cases of assisted suicide occur each year in Holland.²⁷⁶ Further, Dutch doctors report that their colleagues from France, Britain, Scandinavia, and elsewhere admit that they also often intervene to assist suffering patients who request that their deaths be hastened.²⁷⁷ The acceptance of assisted suicide has neither led to the devaluation of human life nor caused the collapse of moral society in the Netherlands.²⁷⁸ Rather, the Dutch law received strong support from the public.²⁷⁹ Moreover, the Dutch experience disproves the popular argument that legitimizing physician assistance will increase the frequency of suicide as the new legislation has not caused such a result.²⁸⁰ The Dutch experience is an important indicator that a country can accept physician-assisted suicide and still remain a productive and moral society.

266. Walter Ellis, *Dutch Give Legal Blessing to Mercy Killing*, THE TIMES, Feb. 10, 1993.

267. Markson, *supra* note 4, at 5.

268. *Dutch Parliament*, *supra* note 265, at A1.

269. *Id.*

270. *Id.*

271. Marlise Simons, *Dutch Move to Enact Law Making Euthanasia Easier*, N.Y. TIMES, Feb. 9, 1993, at A1.

272. *Dutch Parliament*, *supra* note 265, at A1.

273. Ellis, *supra* note 272.

274. *Dutch Parliament*, *supra* note 265, at A1.

275. *Id.*

276. McCord, *supra* note 64, at 22.

277. *Dutch Parliament*, *supra* note 265, at A1.

278. McCord, *supra* note 64, at 22-23.

279. *Id.* at 23.

280. *Id.* at 24.

XI. CONCLUSION

A legal right to assisted suicide may be a logical development of the current judicial trend allowing the withdrawal of assisted feeding from severely disabled patients.²⁸¹ When a physician withdraws food and fluids from a patient, the physician starts a course of action that will inevitably cause the death of the patient. The death, however, will take several days. This death may or may not cause pain to the patient, but it will create a new kind of tension on the medical personnel and family.²⁸² Because death is certain and has been purposely and artificially induced, the long starvation period is a questionable means.²⁸³ This waiting period seems inhumane for both the patient, the patient's family, and the medical personnel involved. It is a cruel twist of logic to legally allow the action of withdrawal of food and fluids in order to bring about certain death, but to prohibit more humane actions of assisted suicide in order to hasten the direct, certain result that has been set in motion.²⁸⁴ Thus, there will be pressure on courts and legislatures to allow physician-assisted suicides. Express legislation is necessary to protect the right of patients to choose the alternative of death with dignity through assisted suicide and also to protect the rights of the physicians who would assist them. With the proper safeguards, such legislation would benefit many in our society by giving them control over their lives and their deaths. Although death with dignity is not acknowledged uniformly as a fundamental right by all states, it is at least being recognized more and more as a humane and enlightened policy.²⁸⁵

281. Rosenblum, *supra* note 216, at 24. Such authorization of withdrawal of food and fluids from patients "who are not terminally ill nor imminently dying will inevitably create pressure in both law and medical practice . . . to hasten the death of a patient in a more 'humane' manner." *Id.*

282. *Id.*

283. *Id.*

284. *Id.*

285. Smith, *supra* note 76, at 418.

